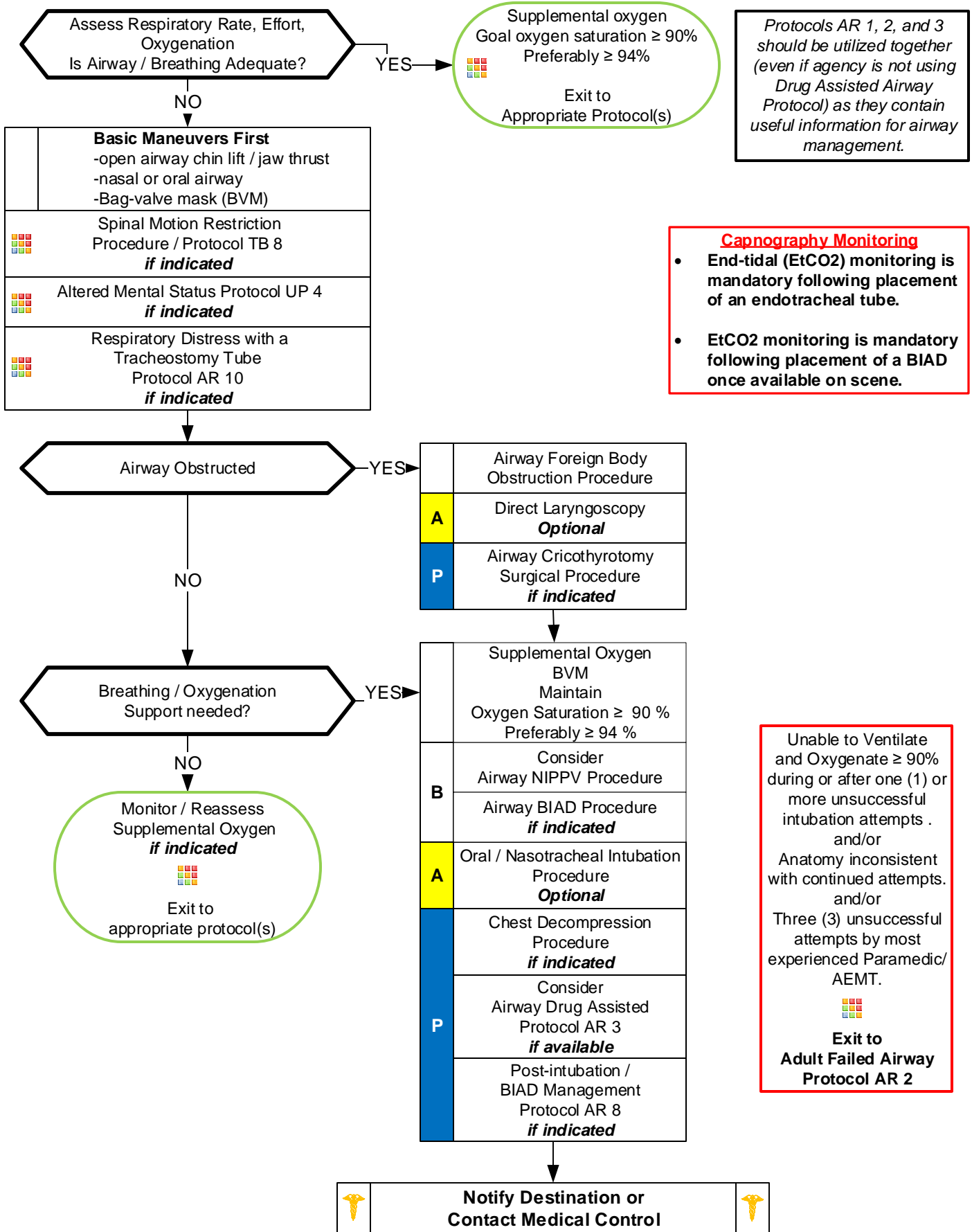


Adult Airway



AR 1

Adult Airway

Capnography monitor strip is required to be attached to the PCR for all intubations.

Pearls

- See Pearls section of protocols AR 2 and 3.
- For the purposes of this protocol a secure airway is when the patient is receiving appropriate oxygenation and ventilation.
- If an effective airway is being maintained by BVM with continuous pulse oximetry values of $\geq 90\%$, it is acceptable to continue with basic airway measures.
- Ventilation rate should be 8-10 per minute to maintain a EtCO₂ of 35-45. Avoid hyperventilation.
- **Anticipating the Difficult Airway and Airway Assessment:**
 - **Difficult BVM Ventilation (MOANS):** Mask seal difficulty (hair, secretions, trauma); Obese, obstruction, OB – 2d and 3d trimesters; Age ≥ 55 ; No teeth; Stiff lungs or neck
 - **Difficult Laryngoscopy (LEON):** Look externally for anatomical problems; Evaluate 3-3-2 (Mouth opening should equal 3 of patient's finger's width, mental area to neck should equal 3 of patient's finger's width, base of chin to thyroid prominence should equal 2 of patient's finger's width); Obese, obstruction, OB – 2d and 3d trimesters; Neck mobility limited.
 - **Difficulty BIAD (RODS):** Restricted mouth opening; Obese, obstruction, OB – 2d and 3d trimesters; Distorted or disrupted airway; Stiff lungs or neck
 - **Difficulty Cricothyrotomy / Surgical Airway (SMART):** Surgery scars; Mass or hematoma, Access or anatomical problems; Radiation treatment to face, neck, or chest; Tumor.
- **Capnography Monitoring (EtCO₂):**
 - Continuous Waveform or Quantitative Capnography and Pulse Oximetry are required for intubation verification and ongoing patient monitoring (Not validated and may prove impossible in the neonatal population- verification by two (2) other means is recommended in this population.)
 - Capnography verification and monitoring is required for BIAD verification and monitoring once available on scene.
- **Nasotracheal intubation:**
 - Procedure requires spontaneous breathing and may require considerable time, exposing patient to critical desaturation.
 - Contraindicated in combative, anatomically disrupted or distorted airways, increased ICP, severe facial trauma, basal skull fracture, and head injury. Orotracheal route is preferred.
- Intubation attempt defined as laryngoscope blade passing the teeth or endotracheal tube passed into the nostril.
- If First intubation attempt fails, make an adjustment and try again: (Consider change of provider in addition to equipment)
- AEMT and Paramedics should consider using a BIAD if oral-tracheal intubation is unsuccessful.
- During intubation attempts use External Laryngeal Manipulation to improve view of glottis.
- Gastric tube placement should be considered in all intubated patients if available or time allows.
- It is important to secure the endotracheal tube well to better maintain ETT placement. Manual stabilization of endotracheal tube should be used during all patient moves / transfers.
- **DOPE:** Displaced tracheostomy tube / ETT. Obstructed tracheostomy tube / ETT. Pneumothorax and Equipment failure.